AMERICAN ARBITRATION ASSOCIATION

In the Matter of the Arbitration Between

PUBLIC EMPLOYEES FEDERATION, AFL-CIO (Union)

-and-

STATE OF NEW YORK
STATE UNIVERSITY OF NEW YORK
UPSTATE MEDICAL UNIVERSITY (State)

RE: Louis J. Cavalluzzi (Grievant)

AAA CASE NO. 13 672 01047 1

OPINION AND AWARD

Before FREDERICK P. DAY, Arbitrator

APPEARANCES

For the Union:
WILLIAM P. SEAMON, ESQ.
PUBLIC EMPLOYEES FEDERATION
STEVEN M. KLIEN, ESQ., Of Counsel

For the State:
HISCOCK & BARCLAY
By RICHARD K. HUGHES, ESQ.

In accordance with the Collective Bargaining Agreement

(Agreement) (Joint Exhibit 1) between the captioned parties, the undersigned was designated to hear and resolve a dispute regarding the Grievant's suspension and termination from employment. Hearings were held at the offices of Action Reporting Services in Syracuse, New York, on February 6, March 25, May 15 and 16 and June 18, 2002. The parties were present with competent representation and were accorded a full and fair hearing, including the presentation and cross-examination of sworn witnesses and documentary evidence and the presentation of oral argument in support of their respective positions.

ISSUE

The parties agreed to the following issues as the only issues before the arbitrator:

1. Is the Grievant, LOUIS J. CAVALLUZZI, guilty of all or some of the charges of falsification of records and poor work performance, contained in the Notice of Discipline ("NOD") dated December 20, 2001?
2. If so, is the penalty of termination of the Grievant, as proposed by the Employer, the State University of New York Upstate Medical University ("SUNY"), appropriate and for just cause, and may this penalty be implemented?
3. If the penalty of termination is not appropriate and for just cause, what is the appropriate penalty, if any?
4. If the Grievant is innocent of all of the charges contained in the NOD, what is the appropriate remedy, if any?
5. Did SUNY have probable cause to suspend the Grievant without pay effective December 21, 2001?
6. If not, what is the appropriate remedy, if any?

In an interim award dated July 15, 2002 the undersigned disposed of the questions posed in issues five and six herein above. The instant award is limited to issues one through four.

NOTICE OF DISCIPLINE

On December 20, 2001, the Grievant was served with a Notice of

Discipline (NOD) and suspension (Exhibit 1).[1] The NOD contains ten charges alleging falsification of records and poor work performance. Charges one through six pertain to events alleging to have occurred on November 7, 2002. Charges seven through ten pertain to events alleging to have occurred during the Grievant's work shift of November 15-16, 2002. The charges read, in pertinent part:

> "1) While working the 7:00 a.m. to 7:30 p.m. shift on 11/7/01, on the Burn
> Unit, you failed to follow the 6:45 a.m. physician's orders for patient L.H.[2]
> (medical record #….)[3] in a timely manner, by failing to completed them until
> approximately 9:00 a.m.
> 2) While working the 7:00 a.m. to 7:30 p.m. shift on 11/7/01, on the Burn Unit, you inappropriately assessed the Internet between 7:00 a.m. and 9:00 a.m., for your own personal use, instead of completing the physician's orders as referenced in charge #1 above.
> 3) While working the 7:00 a.m. to 7:30 p.m. shift on 11/7/01, on the Burn Unit, you failed to date/time the IV tubing and label the maintenance solution bag for patient L.H. (medical record #….).
> 4) While working the 7:00 a.m. to 7:30 p.m. shift on 11/7/01, on the Burn Unit, you inappropriately left 10 mgs of Reglan on the bedside table of patient L.H.'s (medical record # ….) room.
> 5) While working the 7:00 a.m. to 7:30 p.m. shift on 11/7/01, in the Burn Unit, you failed to forward the data correctly to the data port for the EKG you had taken for patient L.H. (medical record #….).
> 6) While working the 7:00 a.m. to 7:30 p.m. shift on 11/7/02, on the burn Unit, after drawing blood from patient L.H. (medical record #….) for a blood culture to be performed, you incorrectly put the blood in a blue top tube and sent it to the lab, instead of the correct isolator tube.
> 7) While working the 7:00 p.m. to 7:30 a.m. shift, which commenced on 11/15/01, on the Burn Unit, at approximately 7:30 p.m., you failed to follow the physicians order to change the rate the TPA IV was infusing at, for patient R.J.[4] (medical record #….), from 20 cc's per hour to 10 cc's per hour.
> 8) While working the 7:00 p.m. to 7:30 a.m. shift, which commenced on 11/15/01, on the Burn Unit, you failed to detect on an hourly basis that the TPA IV was infusing into patient R.J. (medical record #….) at 20 cc's per hour, instead of 10 cc's per hour as ordered by the

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[1] State Exhibits are numbered herein. Grievant Exhibits are lettered in the upper case. Joint Exhibits are identified as "Joint 1, 2 …."

[2] I will herein refer to patient L.H. as "LH."

[3] For the record, the patients were identified by initials and medical record numbers. There is no dispute that the Grievant cared for the named patients during his tours of duty on the dates contained in the charges. I will therefore omit the medical record numbers from this award.

[4] I will herein refer to patient R.J. as "RJ."

physician.

9) While working the 7:00 p.m. to 7:30 a.m. shift, which commenced on 11/15/01, on the Burn Unit, you falsified the medical record of patient R.J. (medical record #….) by documenting on the 24 Hour Flow Sheet that the TPA IV was infusing at 10 cc's per hour throughout your shift, when it actually infused at 20 cc's per hour.

10) While working the 7:00 p.m. to 7:30 a.m. shift, which commenced on 11/15/01, on the Burn Unit, you incorrectly wrote over the numbers on the 24 Hour flow Sheet for patient R.J. (medical record #….) instead of putting a line through the number, writing the word error next to it, and signing your name."

DISCUSSION

I have carefully and thoroughly examined all of the evidence, the transcripts and the arguments in this matter. The record indicates that the patients identified in the charges were indeed patients on the Burn Unit ("Unit") on the days in question and were assigned to the Grievant. LH, a female burn patient, was assigned to the Grievant on November 7, 2001. RJ, a male, though not a burn patient, was assigned to the Grievant on November 15-16, 2001. The record further indicates that the orders contained in the patients' records were legitimate physicians' orders dispensed for legitimate medical reasons. For the sake of brevity, certain medical abbreviations, i.e., IV, EKG, are assumed because they are defined and explained in the record.

Charges 1 - 6

These charges arise from the Grievant's interaction with Patient LH, a patient admitted to the Unit for burn treatment. The Grievant's shift ran from 7 a.m. to 7:30 p.m. He received the patient from nurse Chayka, who cared for the patient on the previous shift.

Charge 1

The Grievant is accused of failing "to follow the 6:45 a.m. physicians orders for [LH] in a timely manner, by failing to complete them until approximately 9:00 a.m." The orders (Exhibit 6) were written by Dr. Singh and were related to an anticipated burn care procedure,

including medications, dressing changes, and tube insertions. Six orders were indicated. One order was specific as to time, that is, "Thorazine 12.5 mg IM @ 8:30." According to the Grievant, Dr. Singh called earlier to assure that the Thorazine would be administered at 8:30. The record indicates that the Grievant administered the Thorazine as ordered at the time ordered. The five remaining orders were related to bedside care that Dr. Singh and the attending physician, Dr. Bonaventura, would commence to administer upon their completion of "grand rounds," which were conducted on Wednesdays at another part of the hospital. When the physicians arrived on the Unit at approximately 9:05 to administer the bedside care for LH, the items ordered were not at the bedside. The Grievant was surprised to see the physicians. He expected them, according to his testimony, closer to 9:30. Dr. Bonaventura was apparently upset[5] that the needed items, including dressings, tubing and a central line kit, were not at the bedside. According to the Grievant, Dr. Bonaventura was upset only because certain medications (not written in the order) were not at bedside. In any event, wound care was delayed because the items were not available when the physicians expected them. Once wound care commenced, the Grievant, who was gowned, masked and gloved, had to request other nurses to bring items that were included in the orders to the bedside.

The record indicates that the ordered items were not at LH's bedside when the physicians arrived on the Unit. The issue is, was the Grievant guilty of "poor work performance" for not having them there? As the charge is written, the Grievant failed to complete the orders "until approximately 9:00 a.m." The record indicates that the physicians arrived on the Unit shortly after 9:00 a.m. Several witnesses testified that the physicians routinely appeared on the Unit following grand rounds at or near 9:00 a.m. Although no time is indicated on the orders for the

[5] Dr. Singh and Dr. Bonaventura were not called to testify.

placement of the ordered items at LH's bedside, I can reasonably conclude, based upon the testimony of the other nurses regarding post grand rounds wound care, that the items should have been available at bedside when the physicians arrived. The record indicates that the Grievant was not overwhelmed with other duties at the time he could have been gathering and placing the materials ordered. Even if, as the Grievant testified, the physicians arrived earlier than anticipated, the time difference involved is marginal. Moreover, there is no indication in the record that the Grievant was even attempting to gather the ordered materials when the physicians arrived. For these reasons, I will sustain the charge.

Charge 2

The Grievant admits that he accessed the internet sometime between 8 a.m. and 8:30 a.m. to search the results of board exams for an physician assistant employed on the Unit. He did this at the request of another person. According to his testimony, which is not refuted as to the details, he was on the internet for less that ten minutes. He then administered the Thorazine as ordered at 8:30, <u>after</u> being on the internet. Although the Grievant did access the internet as charged, I do not find that he was guilty of "poor work performance" in so doing. His time on the internet was short and did not interfere with his work performance. I cannot conclude that the Grievant failed to place the wound care items at LH's bedside because of the time he spent on the internet. He completed the internet time before 8:30 and administered the Thorazine as ordered. For whatever reason he failed to complete the remaining orders, I do not find that his time on the internet had anything to do with it. Therefore, I conclude that the Grievant's time on the internet did not interfere with his work performance. He had ample time

after 8:30 to place the ordered items at the patient's bedside. For these reasons, I will dismiss the charge.

Charge 3

There is no dispute that the Grievant failed to label, with the date and time, the IV tubing and IV solution bag for LH during the morning of November 7. The record indicates that this was in violation of hospital policy. The record also indicates that it is common practice for nurses to label IV tubing and bags some time after hanging, as long as they are labeled in time for the next nursing shift, so that the next shift will know the date and time the bags and tubing were hung. The labeling is deemed necessary by policy for legitimate medical reasons. Between the time the tubing and bag were hung for LH and the time the labeling omission was discovered, the Grievant had been sent to lunch by the Patient Service Leader ("PSL"), Galster, in charge at that time. He was then, before he returned from lunch, "floated" to another unit in the hospital and, through no fault of his own, never returned to the floor to continue care for LH. Under the circumstances, although the Grievant failed to label LH's tubing and bag, I cannot find that he is guilty of "poor work performance" for thefailure. Therefore, I will dismiss the charge.

Charge 4

The Grievant admits to leaving the medication, Reglan, on a counter in LH's room. The medication is used in the insertion of gastro intestinal tubing inside a patient. The Grievant assisted Dr. Singh in placing the tubing. The vial of Reglan left in the room was an extra vial, should the need have arisen to reinsert the tubing after x-rays were taken to determine if the tubing was placed properly. There is some question as to whether the Reglan was left "on the bedside table" or on a counter removed from the LH's bed. In either event, the Grievant admits that the Reglan should not have been left in the room. It either should have been on his person, or, if not needed, disposed of (wasted) properly. Although Reglan is not a narcotic and although LH was not ambulatory

and could not have accessed the Reglan, the medication should not have been left where it was. However, because the charge alleges that the medication was at a bedside table, the overall affect of the charge is diminished by the fact that the charge is partly inaccurate. However, I will sustain the charge, because the Grievant's action indicated "poor work performance."

Charge 5

The record indicates that the Grievant administered an EKG for LH at or about 2 p.m. on November 7. The EKG machine produces a hard copy and holds within it an electronic record of the EKG until the record is transmitted, via a phone modem, to an electronic storage unit at the hospital. The machine, after the EKG is transmitted electronically, erases the EKG to preserve patient confidentiality. The Grievant testified, in unrefuted testimony, that he shared the hard copy of the EKG with Dr. Singh[6] and that he then transmitted the EKG electronically just as he had done on approximately one hundred other prior occasions for other patients. Sometime shortly thereafter, he was notified by the EKG unit that the EKG result received for LH was a flat line. It was therefore necessary to redo the EKG. The second EKG was done by Galster, who replaced the Grievant after he was sent to lunch and "floated" to another unit. The record indicates that the EKG was administered correctly by the Grievant, because a hard copy was shared with Dr. Singh. Without testimony from someone with technical expertise regarding the working of the EKG machine, the transmission system and the electronic storage system, I cannot conclude that the Grievant was at fault for the flat line simply because the data was not properly received by the EKG data port. Presumably, several factors could have contributed to the failure unrelated to the Grievant's performance. Therefore, I will dismiss the charge.

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[6] Galster testified that the EKG machine produces a hard copy.

Charge 6

The record indicates, and the Grievant admits, that he drew blood from LH and sent the sample to the laboratory in the wrong tube. The laboratory so notified the Grievant and a new sample had to be drawn and sent back to the laboratory in the proper tube. The Grievant offers no excuse for this mistake, nor is there one. The tubes are color coded and the codes are readily available and posted for nurses' reference. (Exhibits 11-13). I will sustain the charge.

Charges 7 - 9

I will discuss these charges together, because they relate to the allegation that the Grievant infused, for a sustained period of time, a medication into patient RJ at twice the ordered rate, then "falsified the medical record" of RJ by documenting the prescribed rather than the actual rate of infusion. The record indicates that the medication was Tissue Plasminogen Activator ("TPA"), used as an infusion to dissolve arterial or venous blood clots in adults (The TPA protocol is in the record as Exhibit 20). RJ was transferred to the Unit from the Interventional Radiology ("IR") department, following the insertion of catheters, infusing at two locations, proximal and distal between the clot and the heart. The infusions were started under the direction of Drs. Kwon and Dixon in IR. Both are specialists in interventional radiology. The order, written at 5:50 p.m. on November 15, called for an initial infusion of TPA at 20 cc per line for one hour, then for 10 cc per hour thereafter until 9 a.m. November 16. The Grievant is charged, essentially, with running 20 cc per line per hour throughout the night, then falsifying the record by recording that the lines ran at 10 cc per hour.

I have carefully examined Exhibits 18, 19 and 23 and Exhibit A, as well as the testimony of Dixon, Kwon, the Grievant, Szabo, Marafino and McDonald and, for the reasons indicated below, I will dismiss the charges.

The Grievant maintains that when he received RJ, the TPA lines were both infusing at 10 cc per hour and that they infused at that rate through the shift.

Szabo testified that she found the TPA lines to be running at 20 cc when she first entered RJ's room after taking over the patient from the Grievant. Galster testified that the lines were running at 20 cc when Szabo brought her into the room. Szabo also testified that she changed the infusion back to 10 cc after making the discovery and after initially charting 20 cc at 8 a.m. Based upon her observation, Szabo concluded, as she so reported to the IR physicians, that the lines were "apparently" running at 20 cc throughout the Grievant's shift.

In addition, Marafino, the IR nurse, testified that the TPA was infusing at 20 cc when she handed RJ off to McDonald and a "SWAT" nurse. Mc Donald testified that she took charge of RJ from Marafino at 6:50 p.m. and that the TPA lines were infusing at 20 cc when she reported off to the Grievant and turned RJ over to him at 7:30 p.m. However, despite the testimony from these nurses regarding the TPA infusion rate, I find that the record evidence does not support their testimony. Indeed, it favors the Grievant's account that the TPA lines were infusing at 10 cc per hour throughout his shift.

First, the record is confusing as to exactly when the TPA infusion actually started. Despite Marafino's testimony that she started the actual infusion at 6:25 p.m. on November 15, her charting also indicates that the TPA was started at 6 p.m. (Exhibit 18). Kwon wrote the order at 5:50 p.m. on November 15 and Marafino was present during the order and the procedure. In fact, Marafino prepared the medication by mixing the appropriate amount of TPA in 160 cc of normal saline ("NS"). Assuming that the infusion was started at 6 p.m., it would have been McDonald's responsibility to decrease the rate of infusion from 20 cc to 10 cc at 7 p.m. Even assuming that the TPA was started at 6:25 p.m., it still would have fallen on McDonald to reduce the rate of infusion at 7:25 p.m.,

before the Grievant took over care of RJ. In either event, either by a half-hour or five minutes, it is possible and reasonable to conclude that the rate of infusion had been changed to 10 cc before the Grievant took control of the patient, thus lending credence to his testimony.

Second, McDonald's November 16, 7 a.m. charting of the NS inflow for RJ was listed at 40 cc (Exhibit 18). However, according to the record, the patient was receiving both TPA and Heparin IV. Heparin was infusing in NS at 30 cc, while an additional 10 cc were infusing in another solution (Four lines were infusing at that time). If the NS line on the flow chart measures all fluids in NS, then it would include 30 cc of Heparin. If the 30 cc of Heparin were included, then the NS total would reflect 30 cc of Heparin and 10 cc times two, or 20 cc, of TPA. This tends to corroborate the Grievant's testimony that the TPA lines were infusing at 10 cc when he took charge of the patient. McDonald seemed confused as to what the 40 cc she charted meant. At first she testified that it represented 40 cc of TPA, then she admitted that 30 cc of Heparin was infusing through another line in NS, and that the amount would need to have been included in the NS total. The Grievant changed the chart from 40 to 50 when he charted the total solution being infused in NS at 7 p.m.

Third, the numbers do not add-up to support the State's allegation. Assuming the State's allegation to be true, except for about two hours between 8 a.m. and 10 a.m. on November 16, the rate of TPA infusion was at 20 cc per hour from about 6:30 p.m.(rounded off) November 15, to when both bags per line were empty and the treatment discontinued at 3:15 p.m. on November 16, a total of approximately 20.75 hours. That means, the total volume of TPA solution for 18.75 hours at 20 cc and 2 hours at 10 cc, would have been 395 cc per line. The total mixed and hung between the original bags hung in IR and the additional bags hung by the Grievant, was 320 cc per line.

Further, the numbers and circumstances through the night of November 15-16, support the Grievant. Assuming, (again, rounding off)

the bags started at 6:30 p.m. on November 15 in IR were hung at 145 cc to 140 cc (with either 15 cc or 20 cc used to prime the lines leading from the bag to the point of infusion on RJ), the first hour at 20 cc would have reduced the volume in the bag to 120 cc or 125 cc. If run at 20 cc from that hour, the bags would have emptied at 1:30 a.m. The new bags would have had to be run from 1:30 a.m., until they emptied at 3:15 pm on the 16th. That would have required a total volume of 270 cc (assuming two hours at 10 cc) from 160 cc bags, or 110 cc more than would have been available, assuming the State's theory.

The Grievant's story is the more credible. His orders were to run the TPA at 10 cc per hour until 9 a.m. on the 16th. By his calculation, the bags would have run dry (assuming 140 cc starting volume) by approximately 6 a.m. to 7 a.m. In order to keep the TPA running until 9 a.m., as ordered, he would have been required to hang another bag or flush the 20 cc in the tubes with NS. He could not flush the remaining TPA without an order, so he hung new bags at 6 a.m. He estimated that there was about 10 cc in the bags when he changed them and he changed them at 6 a.m., because he did not want to run the risk of the infusion pump alarm sounding between 6 and 7 a.m.,[7] thereby unduly disturbing RJ before the normal patient check at 7 a.m. The remaining TPA was continued, by the Grievant's account, at 10 cc from 6.a.m. The volume was raised to 20 cc at IR at 10 a.m. and continued until 3:15 p.m. That would have used about 140 cc from 6 a.m. to 3:15 p.m. (40 cc between 6 and 10 and 100+ cc between 10 and 3:15), and although the total is short by approximately 10 cc to 20 cc, (assuming a starting volume of 160 cc in each bag) the numbers are much closer to the Grievant's account than to the State's.

Fourth and finally, Between the time the Grievant signed-off RJ to Szabo on the 16th and Szabo actually went into RJ's room and found the

[7] According to McDonald, the alarms were activated at 7 p.m. on November 15. (T- p. 306)

TPA to be infusing at 20 cc, a surgical team visited the room and performed a patient examination and evaluation. The person who signed the progress notes (appears to be K. Bukley or Boxley), noted the TPA lines running at 10 cc (Exhibit 23). This further corroborates the Grievant's story. Although the State attempted, through Dixon, to suggest that perhaps the evaluator simply copied the RN's flow chart when he or she noted the TPA infusion flow, Dixon's testimony only tends to underscore the actual note-maker's absence from the witness stand. I must weigh such absence in favor of the Grievant, since that person, or other persons from the surgical team, would have shed a brighter light on what the notation was intended to convey.

Charge 10

The record clearly indicates, and the Grievant admits, that he made the change in the manner charged in this allegation. Furthermore, the record indicates that the Grievant did so against hospital policy. However, the record also indicates that others, including State witnesses in these proceedings,[8] have done the same. The record also indicates that no other perpetrator so identified has been disciplined or counseled for identical infractions charged against the Grievant. Under the circumstances, I cannot find that the Grievant is guilty of poor work performance when identical performance among other employees, including nurses and physicians, is clearly tolerated. This charge will be dismissed.

[8] I will not name the persons, since it serves no purpose herein.

AWARD

The undersigned, for all the reasons herein above, after careful consideration of the entire record, the arguments by the parties and by a preponderance of the evidence, awards as follows:

1. The Grievant is guilty of some of the charges of poor work performance contained in the NOD dated December 20, 2001; to wit: charges 1, 4 and 6.
2. The penalty of termination from employment is not appropriate.
3. The appropriate penalty is: a letter of reprimand addressing the actions described in charges 1, 4 and 6 shall be placed in the Grievant's personnel file.
4. The Grievant shall be reinstated to the position he held at the time of his suspension and discharge, with all appropriate back pay and restoration of accruals and benefits pursuant to the Agreement.

DATE: October 6, 2002 SIGNED _____/S/_____

I, FREDERICK P. DAY, do hereby affirm upon my oath as Arbitrator that I am the individual described in and who executed this instrument, which is my Award.

_____ _____